Form II

KENTUCKY BOARD OF PHARMACY

PHARMACIST PRECEPTOR'S AFFIDAVIT

Form II must be submitted in **duplicate** within **ten (10) days** form the beginning of internship. Form II must be **resubmitted** in duplicate within ten (10) days if **change in Pharmacist Preceptor**. Please mail certified, return receipt requested to: Kentucky Board of Pharmacy, 23 Millcreek Park, Frankfort, KY 40601-9230. Telephone (502) 573-1580.

Pharmacist Intern's Name _____

Pharmacist Intern's ID Number _____

Pharmacist Preceptor's Name _____

Pharmacist Preceptor's License Number _____ State of Licensure _____

Full Name and Address of Pharmacy _____

_____

Pharmacy Permit Number _____

Pharmacist Intern's Starting Date _____

- A Pharmacist Intern shall be assigned to process prescriptions and counsel patients not less than 66% of the time spent in the pharmacy and may not be left in charge of a pharmacy.
- I shall maintain personal supervision of the Pharmacist Intern on a one-to-one basis and fully understand that a Pharmacist Intern cannot legally compound or dispense prescriptions except when doing so under the immediate, personal supervision of a certified pharmacist preceptor.
- I affirm that I will adhere to the requirement of the "Pharmacy Internship Policy" and the requirements of Kentucky law and administrative regulations.

_____ _____

(Date) (Pharmacist Preceptor's Signature)

(It is the Pharmacist Intern's responsibility to submit this form to the Kentucky Board of Pharmacy office within the required time limitation.)